

**District IV Citizen Review Panel Meeting  
Central District Health Department  
707 N. Armstrong Place, Boise, Idaho  
Tuesday, February 4th, 2020 ~ 4:00 PM – 6:00 PM**

**Panel Members Present:** Brian McCauley, Nicole Noltensmeyer, Kym Nilsen, Melissa Mezo, Teri Murrison and Darcie Bobrowski; Shannon McCarthy arrived at 4:05pm

**Staff:** Courtney Boyce (Central District Health), Laura Smith (Central District Health) arrived at 4:15pm

**Absent:** Misty Myatt (Idaho Department of Health and Welfare (IDHW))

**Call Meeting to Order**

Brian McCauley, Panel Chair, called to order the District IV Citizen Review Panel meeting at 4:00 PM.

*Motion:* Darcie requested to amend the agenda as she was not present for the Case Review with Roxanne Printz. This was amended.

*Motion:* Teri motioned to approve the agenda. Darcie seconded. All in favor, motion carried.

*Motion:* Teri motioned to approve the meeting minutes from the January 7, 2020 meeting. Melissa seconded. All in favor, motion carried.

Courtney discussed the need to collect in-kind hours and number of case reviews from the panel, for the quarterly report. Courtney discussed the format of the quarterly report and how these numbers were from the time between each meeting. Out of the interest of time, Courtney will email the citizen review panel a copy of the drafted quarterly report and request case review numbers and in-kind hours. In the future, the panel will indicate at each meeting, their in-kind hours and number of case reviews completed from the last minute. Courtney indicated that the in-kind hours for the report will include transportation and the time at meetings, however the hours she needs from the panel would be unaccounted time spent on behalf of the CRP.

**Case Review with Roxanne Printz**

Darcie discussed case review with Roxanne Printz, the deputy division director of child protection at the Idaho Department of Health and Welfare. This was done via webEx, with Courtney from CDH on the call. Another IDHW employee was on the call as well, assisting with notes and the development of the eCabinet technology. Darcie stated that she did not prep for the meeting by opening up eCabinet, but wanted to go in with new set of eyes to the adjustments that have been made and provide her first impressions.

Darcie started the case review by looking for the adjudatory report. This was missing from eCabinet. Darcie identified improvements with the ‘tabs’ in order to effectively search for data relevant to the CRPs and other topics. Darcie discussed that on the call, it was discussed that the ‘effective date’ selection needed to be more accurate, indicating the date that the paperwork was filed or completed, not the date that it was entered into the system.

Darcie discussed that her process of case review indicates the “why’s” of the case, and the difficulty of accessing information as it is spread throughout the system. Brian stated that this reinforced the need to speak to foster care parents to help bridge inconsistencies in the data, and provide more context to the reports. Darcie stated that she did discuss this on the call with Roxanne, and re-iterated that

the District IV citizen review panel is taking a systems change approach, and does not want to get involved with the specifics of cases. Darcie stated that she discussed how answering these questions will help the panel identify trends. Darcie said that the panel would not use contact with the foster parents inappropriately to vent or blame the department.

Darcie discussed the placement changes and the copy-paste language of the reports. Darcie indicated that Roxanne had discussed how they are working on changing the format of the forms and the content to clarify language. Darcie discussed that Roxanne indicated that 80% of children experience one placement with Idaho's foster care system, and their reunification statistics. Brian discussed that data discrepancies from the department may be different from CRP observations, may be explained as that statistic includes all cases of children, regardless of their timeline in care. As the panel is reviewing cases older than 120 days, this may explain the CRP's observations may not be congruent with department data. Courtney will put in a request to verify the statistics that Roxanne mentioned on the call.

Darcie discussed that Roxanne wanted the District IV CRP to increase utilizing Misty, the IDHW liaison, as a resource. Darcie discussed that other CRPs are in much more frequent communication with their department liaison, and if needed, the CRP can contact Misty with questions.

### **Statewide CRP Leadership Call Update**

Brian, Darcie, and Courtney were all on the state wide CRP call. Brian discussed that during the leadership call, he discussed the difficulty of contacting foster parents, and how someone told him about an email that was sent out to the PHD liaisons and IDHW. This email was forwarded to him after the meeting and discussed with him over the statewide leadership call. The email stated that the IDHW had additional legal counsel, and determined that with consent from the foster care parents, the citizen review panel members could speak to foster parents. The email discussed the MOU requirements as to not disclose any identifying information. This process will be implemented by Feb 1<sup>st</sup>, 2020, and requesting a minimum of three business days per request to obtain consent.

Brian identified this as a success for the panel, and re-iterated that the department is concerned about violations of confidentiality, and CRP members will need to very consciousness when contacting consenting foster care parents. Panel members are aware of the purpose behind contacting foster care families, and will observe the MOU.

Brian continued to discuss other aspects of the statewide leadership call, indicating that there were new representatives from Region V. Brian talked about the developing direction of other panels, but that there was a lot of support from other CRPs behind District IV's initiatives. Brian discussed the value of legislature representation on the calls, in to influence the direction and progress of the panels. Brian discussed there may be concerns of re-election and divesting responsibility to other stakeholders. If some party members are not re-elected, it will change committee assignments as the political environment changes. The goal is to make sure the panels and committee members do not lose focus, and ensure a sustainable approach to child welfare systems change.

Darcie discussed how on the call, the group identified sending one major recommendation to the legislative oversight committee at a time, rather than providing separate reports. Darcie stated that the IDHW is building this technology, and the snapshot needs to be implemented. The idea of what the CRPs want to integrate, what changes need to be made, and what would function best. Melissa inquired about whether or not there was a conversation regarding the future of the meetings, and who would be facilitating it. Darcie said that this was addressed, but not resolved. Brian discussed the recommendation of having members of legislative oversight committee meeting to attend state-wide call. Brian also discussed the recommendation that each panel have time set aside during the legislative oversight committee meetings to discuss regional-specific issues. Darcie reiterated that other CRPs are concerns of

disbanding, whereas District IV is receiving consistent feedback via Senator Lee. Kym re-iterated the value of these recommendations including the snapshot template, as it could save hours and draw everybody to one page. Kym discussed that individuals would be able to easily identify multiple placement changes, leading to the question of “why?” Nicole stated that she wants to see the bar on the current draft template, be visually extended to clearly indicate the length of time that a child is in care. Kym discussed how time in treatment can lead to broken children, and this visually identifies the story without requiring four hours of case review. Nicole, Brian, and Darcie shared similar statements of agreeance.

### **Introduction to Speaker, Britney Journee**

Melissa provided an introduction to Britney Journee, a licensed clinical professional counselor. Melissa stated that Britney and she have worked together for roughly 19 years as they started at Terry Reilly Health Services (TRHS) around the same time. Britney brings to the table a lot of experience with ACEs and trauma-informed care and leads trauma work via TRHS through a team of long-term counselors and school-based counselor. Britney supervises roughly twenty people and has wealth of knowledge that would be beneficial for this panel. Britney works on a number of child protective services and been to court several times to testify, and worked closely with IDHW. Britney followed up indicating that half my panel of clients have a history with IDHW involvement. Britney is employed through TRHS, however the information and opinions she expresses at this meeting are her own and not a representation of TRHS.

Britney stated the difference in care approach, indicating that one of the things that SANE Solutions does when foster care children are in care, we keep them in care until they are adopted to have the consistency of care, or adjusted with their families after reunification or kin placement. Teri questioned about the difference between FACES, TRHS, and SANE. Britney answered saying that individuals that have indicated sexual abuse or trauma, receive a CARES interview at FACES but they are referred out for services. SANE Solutions is where people are referred out to for care from the family justice center. SANE Solutions is contracted for employment under TRHS. SANE Solutions provides specialty services. Britney indicated that because of their referral system, they work with children and adults involved with the child welfare system. TRHS and SANE provides integrative care that is a requirement of the case plans for parents.

### **Trauma-Informed Care Presentation**

Britney began presentation after intro slides, to discuss the important factors for meeting the needs of foster care children. The child has a minimum of two traumas the precipitating event and then being removed from parent’s care. A trauma-informed lens with especially with foster care children identifies that there are always multiple traumas prior to introduction to services. Britney stated trauma that occurs in childhood and neglect, will lead to further repercussions. Trauma-Informed Care (TIC) is the strategy to help manage and overcome issues. It is a responsibility of those in behavioral health to identify trauma needs in all ages, although we hope to reach them in childhood. Britney identified that it takes a village of support from case workers, school teachers, foster parents, counselors etc. TIC in action requires that all parties be involved. A trauma informed system indicates that all programs and agencies infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. This means that from foster parents, teachers, to case managers and beyond – all need TIC training and continuing education. Britney stated that trauma-informed lens and approach helps everyone be on the same page, and comprises of coordinated communication efforts.

Britney reviewed the seven ‘Ingredients for Trauma Informed Care,’ which are as follows.

1. Routinely screen for trauma exposure and related symptoms.
2. Use evidence-based, culturally responsive assessment and treatment for traumatic stress and associated mental health symptoms.
3. Make resources available to children, families, and providers on trauma exposure, its impact, and treatment.
4. Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma.
5. Address parent and caregiver trauma and its impact on the family system.
6. Emphasize continuity of care and collaboration across child-service systems.
7. Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff wellness.

Britney elaborated on each of the ingredients, starting with screening for trauma exposure and related symptoms. This would include exposure to Adverse Childhood Events/Experiences (ACEs) and other traumatic events. Britney discussed that trauma is loosely defined as anything we are not prepared to handle, which she provided examples and elaborated on through the next slide. Britney stated that one of the tools to identify exposure to trauma is ACEs, which identifies what happened to an individual prior to turning 18. Britney described ACEs, from a transcribed from slide image below:

*Adverse Childhood Events*

- 1) Abuse
  - a. Physical
  - b. Emotional
  - c. Sexual
- 2) Neglect
  - a. Physical
  - b. Emotional
- 3) Household Dysfunction
  - a. Mental Illness
  - b. Incarcerated Relative
  - c. Mother Treated Violently
  - d. Substance Abuse
  - e. Divorce

Brian asked about the portion under household dysfunction indicating the mother was treated violently, as a trigger for ACEs. Britney elaborated that this was one-sided, and an Adverse Childhood Event would include domestic violence exposure from/by/with either or both parents. Kym asked about men coming in and out of the home, and wondering where that fits into the ACEs image. Britney elaborated that would be under emotional neglect, because when you don’t feel safe in your own home that is neglectful, and continued this could also include people that the child don’t know or people that scream, when they generally feel unsafe, or when children are left alone for extended periods of time – that would also be categorized under neglect. Britney followed up by saying the slide indicates incarcerated relatives under

household dysfunction, but if that was modernized, she would state that deportation also counts under this category.

Britney continued on a separate slide, following that the higher the ACEs score, the higher risk of certain behaviors. The slide image is transcribed below:

- 1) Behavior
  - a. Lack of Physical Activity
  - b. Smoking
  - c. Alcoholism
  - d. Drug Use
  - e. Missed Work
- 2) Physical & Mental Health
  - a. Severe Obesity
  - b. Diabetes
  - c. Depression
  - d. Suicide Attempts
  - e. STDs
  - f. Heart Disease
  - g. Cancer
  - h. Stroke
  - i. COPD
  - j. Broken Bones

Britney continued with the next slide titled the Ace Pyramid. Brittney stated that a lot of children's risks are associated with their parent(s)' trauma, found in historical trauma and intergenerational adversity at the base the pyramid. As one goes up the pyramid neurodevelopment and epigenetic influences ACEs, with adaptations into social, emotional and cognitive functioning, health risk and behaviors, disease, disability, and social problems, which made lead to an early death. The pyramid indicates this is a whole life perspective through the transitions 'up' the pyramid, from preconception to death with compounding trauma.

On the following slide, is a graphic indicating the 'Impact of Childhood Trauma.' Britney indicated each of the categories including brain development, cognition, physical health, emotions, relationships, mental health and behavior all correlate back to the pyramid, but are specific examples. Britney stated that we are trying to work towards longevity and health towards each individual and emphasized children and parents need to work dually, collaborative support to mitigate trauma. The following slide indicates percentages behind high risk behaviors and patient health outcomes, indicating that a large portion of many health, safety and prosperity conditions are attributable to ACEs.

Britney discussed what a trauma-informed care conversation is and what it looks like. Britney stated that shifting the conversation into a trauma-informed lens and omitting the bias that we generate as a community, allows us to ask "What happened to you?" instead of "What's wrong with you?" Britney indicated that historically ACEs was used by medical providers to shift their lens of focus within their sessions with patients from medical to behavior.

Kym inquired about connecting ACEs to trauma from a previous slide. Britney provided the analogy that two people may be in the same car accident, but that one of them perceived their life was at risk, while the other did not. The negative emotion one person feels, may include fear, hopelessness, and negative beliefs such as 'I am going to die,' or 'I should have stopped it.' This manifest into stomach aches or headaches. Brian addressed resiliency in research and wondered if it still counts as ACEs.

Britney discussed that when people have high ACEs scores and a low resiliency score, this changes how they perceive the event. Britney discussed many people can function well with high ACEs, when they have high resiliency.

This conversation transitioned into the next slide that discussed how trauma does not always lead to the same response, as it affects each person differently depending on their risk and protective factors. Risk factors include parental stress, substance use, and poverty, whereas protective factors include parental resilience, nurturing and attachment, knowledge of parenting and child development, support in time of need, social connections, and the social-emotional competence of children.

Britney discussed screening children for trauma responses. Case workers are looking for an avoidance of trauma-related thoughts or feelings. Britney provided an example of intrusive thoughts. Brittany presented on screening process and transitioned into treatment, as the second ingredient for trauma-informed care. Treatment includes counseling with children and adults including different types such as EMDR, CBT. Any type of treatment is more beneficial with biological parents involved. Shannon asked about parental involvement. Brittney identified sometimes the biological parent is involved in the session, but mainly involving parents through discussion. Britney specified that everything is a case-by-case basis, and prioritizing what is best for the child's treatment. Britney provided an example of how she prefers biological parents be involved when addressing termination, so that the child knows they are loved, they matter, and that they count. An example of treatment provided in the slides was EMDR. Brian said he was aware that EMDR is difficult with young children, so he wondered how that method was utilizing with young children. Britney said that it is sometimes a creative adaptation, to change the therapy into a story format as to use story-telling to reduce stress. Sometimes it is a simple story that is provided through pictures, when providing taps. Britney identified that children are also taught how to breathe, conduct belly breaths, and perform progressive muscle relaxation as a way to clear trauma from the body. Britney emphasized that the coordination of care is beneficial when addressing psychotropic medications, through behavioral health workers, case workers, and communication from the individuals. Britney addressed that Community Based Rehabilitation Services (CBRS) can be helpful as it models appropriate behavior and communication.

Britney stated that the third ingredient for trauma-informed care is providing resources on trauma exposure, its impact and treatment. This would include P.R.I.D.E. classes, Protective Parenting Program, parenting classes, and counseling for children, parents, and adoptive parents. Britney discussed the process for determining what interventions that did and did not work for the individuals and their families, and how to work with kids with a trauma background and hope to enhance skills in the future.

Melissa inquired about contract with IDHW to provide classes, and Kym requested more information about PRIDE classes. Darcie, Nicole answered regarding PRIDE classes, and Britney discussed the contract for services. Nicole re-iterated that PRIDE components are not integrated into TRHS classes. Teri discussed the differences between what we can learn about trauma versus what is taught in classes, and wondering how many children are provided trauma-informed care resources.

Britney identified that a case worker is able to determine what the case plan is and to maintain the continuation of the plan. She discussed that if a child is removed, she would hope all parents are referred to protective parenting classes. These classes provide parents with information, tools, and a supportive environment as they are working their case plan with the goal of reunification or development of a safety plan. Britney discussed in the class there is an expectation of having parents create their own safety plan at the end of the class which would include historical and current factors that created/impede reunification, prevention steps and intervention resources. Britney specified that Protective Parenting classes are for all conditions that may lead to removal of a child, but identified patients for SANE are referred due to sexual abuse. Britney identified that these classes are helpful for anyone, as long as they are open and receptive to learning. Britney stated that there are steps with domestic abuse cases, in order for parents to be accountable and open to their learning. Britney stated that sometimes, facilitators

provide referrals to parents for services outside of the classes, so that they can be open to the discussion required of their case plan.

Britney discussed that the forth ingredient for trauma informed care is to strengthen the resilience and protective factors of children and families. Britney identified that resilience is the power to recover readily from adversity or change as it is a set of capacities. Britney identified that resilience factors are feeling social, emotional support, and hope from two or more people who can give concrete help when needed. Britney identified that this includes community reciprocity where someone has your back, and provided the example of watching out for children. Another component of resilience factors is social bridging where you reach outside your social circle for support and resources, and utilizing peers as resources. Resilience skills include communication skills, learning to problem solve, asking for help, mastering a skill, and establishing consequences among others. Kym identified that resilience factors may be perceived as less reliable when foster children are moved back to the primary family from a foster family, or moving foster homes.

Britney stated that the fifth ingredient for trauma-informed care is addressing parent and caregiver trauma. Britney discussed that children who enter into foster care typically have a common belief about themselves and these conditions, as addressed by Kym, can make it worse by thinking that something is wrong with them. Britney continued that parents of these children typically have similar beliefs about themselves, and experienced similar adverse events when they were children. Britney continued that it is important to discuss how ACES impact ability to parent and continued that it is not just addressing social determinants of health, getting a job/stable housing, or leaving relationships – it is addressing core beliefs.

The sixth ingredient for trauma-informed care includes emphasizing continuity of care and collaboration across child-service systems. Britney provided an example including that there is a Spanish speaking family with four children, with 3 children abused directly and 1 exposed to abuse with an unstable housing situation. A trauma-informed view of care appears as a collaboration and coordination of resources including transportation, multi-agency, time and empathy. Britney continued that this situation may include case worker, foster parent, teacher, and therapist all addressing care, with other therapist in protective parenting classes for the biological parent and a referral to CBRs. Britney addressed coordinating resources across the spectrum, between foster parents, foster children, and biological parents.

Britney identified that the seventh ingredient to trauma-informed care is addressing staff wellness by addressing secondary trauma. By addressing trauma in staff it creates a culture for staff support, this includes general wellness such as yoga, meditation and exercise. On an organizational level this includes fostering a culture where it is encouraged and acceptable to seek support. Examples include using employee assistance programs, and keeping caseloads manageable. Another component is education that includes trainings to create awareness on the dangers of chronic emotional stress and the importance of self-care. Britney identified that education is important for everyone including foster parents, therapists, and secondary trauma.

Britney identified there are ten key dimensions behind trauma-informed care, as dictated from the slide:

- 1) Lead and Communicate
- 2) Engage Patients in Planning
- 3) Train All Staff
- 4) Create a Safe Environment
- 5) Prevent Secondary Trauma
- 6) Build an Informed Workforce
- 7) Involve Patient in Treatment
- 8) Screen for Trauma
- 9) Use Trauma-Specific Treatment
- 10) Engage Partners

## Q & A

Brian discussed that coming from his experience as a foster parent, he did not see IDHW identify trauma within case plans and education. Brian was interested in knowing if it is reasonable or possible that all foster care children receive an ACEs score, so that every person that interacts with that child is able to provide their ACEs score as a lens for their care. Britney indicated that ACEs scores are a historical gathering of information, but do not quantify the exposure/abuse, as there is limited information such as length of time being left alone, or the number of occurrences of neglect.

Brian provided the recommendation that all children need an ACE score. Teri continued that the primary care taker's ACEs score would also be beneficial. Darcie also indicated that the resiliency piece within ACEs scores is also valuable to consider. Britney continued that resiliency is self-reported and not validated, and is used as part of the intake but a separate score-taking process. Resiliency is for teenagers or above, ACEs score is not done in a dialogue with younger children, although it could be derived from case review. Case workers should be evaluating ACE score and identifying lens of how ACEs influences individuals. The discussion continued with the snapshot template that indicates the biological parent(s) and child's ACE score. This could be through a visual format, stating that the visual on slide nine could be used as an adaptation, where each time that an ACE occurrence is identified, it could be correlated back to the reports. The snapshot would be where these images are highlighted identifying the total ACEs score, but also where within the reports it is verified.

Teri discussed that identifying ACEs with case reviews might require an ACE coordinator. Nicole followed up that caseworkers among others might be able to do that within the reports. Nicole requested knowing how referrals are provided, and the process of vetting providers that conduct trauma-informed care. Britney identified that CARES interview needs to be done and to be reported, so that behavioral health services through another agency doesn't contaminate the report. Teri addressed the benefits of the data of knowing ACEs score. Brian contextualized examples of how ACE scores can change behavior, and made recommendation for all foster children needing ACEs score. Shannon discussed how having biological parents would also benefit from scores. Brian re-iterated the need to make actionable recommendations but that this would be a good first start.

Darcie wanted to know what Britney would like to see from a trauma-informed care system. Britney stated that accurate assessments of parents helps develop the plan for treatment, and that this could be an ACE score and resiliency score because that informs the case plan. Britney stated that standardize recommendations would not dictate individual treatment efforts, but standardized scores can provide recommendations. Teri discussed how the department was doing trauma-informed care, and identified the need to continue movement after initial education to provide information and support to caseworkers. A panel member also wanted to know if there are different tiers of the foster care system, or if the entry education is also standardized. The panel addressed that this TIC education could be more impactful when conducted in the PRIDE classes. Brian empathized the benefit of having quantifiable data behind ACEs in foster care cases. Teri discussed wanting to know where food insecurity or hunger falls into the ACEs score. Britney emphasized that would fall into the emotional/physical piece of trauma, but wants to identify that poor social determinants of health including poverty, do not automatically equate to ACEs.

## State-by-State Review of Child Welfare Policies and Programs

Courtney started the presentation shortened to, Policy Analysis from the agenda. All of the appropriate citations were made within the slides, and some segments of discussion are direct quotes.

Courtney started the presentation by identifying the three different types of policies that the CRP can make recommendations on. At the lowest tier is trauma-specific, which is intended to increase access to interventions and services that reduce the impact of trauma and promote healing. An example of this is Medicaid reimbursement for trauma-focused treatment. The middle tier is trauma-informed, which increases awareness and promotes trauma-informed practices. An example of this is mandatory trauma

training for staff. The highest tier and the most impactful, is trauma-preventative as it creates conditions for safe, stable, nurturing relationships and environments and reduces exposure to trauma. Examples are family-friendly work policies, including paid leave and livable wages.

Courtney identified that this goes back into the public health impact pyramid, the highest portion of the pyramid is counseling and education and going further down the pyramid continues with clinical interventions, long-lasting protective interventions, changing the context to make individuals default decisions healthy and the lowest base of the pyramid includes socioeconomic factors that influence social determinants of health. As you go up the pyramid, it requires increasing individual effort needed, with less population level impact. As you go down the pyramid, it increases the impact on population level health. As it pertains to the three types of trauma-related policies, clinical interventions and counseling/education would account for trauma-specific policies. Trauma informed policies would include clinical interventions and long-lasting protective interventions. Trauma preventative includes changing the context to make individuals default decisions healthy and socioeconomic factors.

The presentation started with Washington first, as they are one of the only states that has integrated a comprehensive data evaluation plan within community-based and statewide efforts. In some areas, the results of local initiatives are able to be evaluated more easily due to smaller population size. Courtney discussed the history of Washington's efforts stating that it was initially coordinated statewide by the Family Policy Council that developed the Self-Healing Communities (SHC) model. This model is defined as a process model that builds up the capacity for the community to develop new cultural norms and therefore, improving health, safety, and productivity for current and future generations. The results of this study were through Cowlitz County, Washington over a 10 to 15 year period of analysis. The results included: Births to teen mothers went down 62% and infant mortality went down 43%; Youth suicide and suicide attempts went down 98%; Youth arrests for violent crime dropped 53%; High school dropout rates decreased by 47%; with similar results were seen in other counties. The cost was an average of a \$3.4 million budget per year from 1994 to 2011. The per-year avoided caseload costs in child welfare, juvenile justice and public medical costs associated with births to teen mothers were calculated to be \$27.9 million, based on prevented cases between 2002 and 2006. Taxpayer savings from Network-improved rates from 2002 to 2006 were conservatively estimated at an average of \$120 million per year. Overall, the cost/benefit ratio for this investment is impressive: for every dollar spent, 35 dollars were saved.

Nicole stated that she was an emergency room nurse in Cowlitz County, Washington, and indicated that these figures did not match up the reality of her lived experience, that the community was still struggling, and she did not see the impact of this model impact the community as the data suggests. Courtney identified the citation for the resource was located in the slides, in order to review their methods and research.

The next state is Missouri which has developed a trauma-informed practice and policy toolkit and process model that has been adapted by several other states. Courtney discussed that Missouri developed a statewide trauma roundtable in 2012, as a multi-agency 'think tank', to develop a framework for addressing change and policy guidance. Missouri also implemented Senate Bill 638 that established a Trauma-Informed Schools Initiative. A trauma-informed school recognizes the widespread impact of trauma while understanding all the paths for recovery, recognizes signs and symptoms of trauma in all students and staff, integrates trauma informed policies, practices, and programs and actively seeks to resist re-traumatization. Missouri also implemented a first responder trauma training in 2017.

The Missouri Model of Trauma-Informed Process was developed in 2014 and from the statewide trauma roundtable. The purpose of this model is to assess the implementation of basic principles of trauma informed approaches into various organizational settings. The first step is trauma-aware, where staff is comfortable discussing trauma, and the impact of trauma. The second step is trauma-sensitive, where staff supports are developed, all staff trained, and organizational readiness is in place. Trauma-responsive is change and integration including changes in the environment, a renewal of policies, and

skills training. Trauma-informed is the last step to community engagement, ongoing measurement, and sustainability.

The results of the Missouri model are found through improved academic performance in students. Based on the initial development period of the program, the annual cost for a classroom of 20 children and their community of caregivers to participate in the Trauma Smart model is approximately \$9000, roughly 25% the cost, and a savings of about \$24,000.

The next state under policy analysis is Wisconsin. In 2008, a statewide trauma coordinator was hired. In 2009, the Menominee tribe hosted a summit on historical trauma and adopted a comprehensive trauma-informed approach. In January 2014, Wisconsin became the first state to pass joint resolution on child trauma, with the integration of seven state agencies. In 2016, the governor created a learning collaborative for state agencies. In reference to policies, this would be an example of trauma-informed policies with mandatory learning. In 2017, First Lady of Wisconsin convened national meeting to discuss trauma-informed care, social determinants of health, infant mortality, foster care, and the opioid crisis for First Spouses. Eleven First Spouses attended and left with information on how to initiate social service system and community reforms within their own state. In 2018, Wisconsin led a successful effort to pass federal Congressional resolutions.

The results indicated several improving factors. Menominee Indian Tribe of Wisconsin began educating and integrating practices based on ACEs science. Hundreds of tribal members have been educated about ACEs science, starting with historical trauma. The schools have integrated trauma-informed practices with the result that graduation rates soared from 60 to 99 percent. Significant reduction in self-reported substance use in high school students. Reduced births from teen mothers from 20 a year, to 5 a year. Worker's burnout rates dropped 23 percent and secondary traumatic stress rates dropped 42 percent over three years. In addition, the number of children placed outside the home dropped 15%, and kinship placements increased. Wisconsin Economic Development Corporation voluntary turnover rate decreased from 21% to 3%.

Courtney stated that she wanted to discuss Tennessee briefly as Teri had conducted a discussion regarding Tennessee's trauma-informed care efforts in November 2019. Courtney stated that Tennessee was focusing on working upstreaming, as prior they had directed most of their efforts to downstream resources, including incarceration, drug treatments, health care, and the juvenile justice system. These programs and practices occur after ACEs has occurred, and through the life span. Tennessee as working on preventing ACEs, and creating a state-wide system of prevention, education, awareness, and treatment.

Florida has an interagency workgroup to address trauma, and developed the Early Childhood Court, in order to improve child safety and well-being. The Florida legislature added trauma-informed language to the juvenile justice bill. In 2016, Florida published a trauma-responsive courts tool kit. In 2018, there was the first statewide convening of trauma-informed care efforts. The results in Gainesville indicated reduced arrests of African American youth by 50%, with significantly reduced child abuse.

The next section of the slides indicating Idaho's currently written policy to other states. In Alaska Senate Bill 105, Section 47.05.060, under purpose and policy relating to children, identified that it is the "It is the policy of the state to acknowledge and take into account the principles of early childhood and youth brain development and, whenever possible, consider the concepts of early adversity, toxic stress, childhood trauma, and the promotion of resilience through protective relationships, supports, self-regulation, and services." This was compared to Idaho Senate Bill 1341, Section 16-601. Alaska's policy was compared to Wisconsin Senate Bill Joint Resolution 59, that uses similar language but adds "for a more prosperous and sustainable state through investing in human capital."

Idaho's Senate Bill 1341, Section 16-601 was also reviewed, with indications that there were room for amendments, such as "best interest," "prevent the accrual of avertible adverse childhood experiences." It was discussed that previous efforts towards a foster parent bill of rights was unsuccessful in 2016. Idaho Senate Bill 1341, Section 16-1662 Idaho Code, were also reviewed as it could be added

under the review hearings to add “trauma informed care,” which may include assessments, integration in the case plan, and for children, biological parents, etc. Later on in this same bill, it was also identified that regarding psychotropic medications, it may be there may be room for amendments “evidence-based trauma-informed practices.” Other federal bills were on the slides but were not presented including H.R. 1757, H.Res. 443, S.774, and H.R. 1757.

## **Q & A**

Idaho policy was reviewed, although the CRP did not make any formal recommendations, and does not formally endorse and current or proposed amendments. In conclusion, Darcie stated she would be creating a one-page document for case reviews. The panel would be providing the recommendation for ACE evaluations on our next report, which is due February 14, 2020. Courtney will follow up with the IDHW and Brian, on whether or not BRFSS tracks ACE scores. For case reviews this month, each panel member will be assigned two cases. Contact for the foster parents will be requested for each case.

**Adjournment:** Brian adjourned the meeting at 6:20 PM.

The next meeting is Tuesday, March 3<sup>rd</sup>, 2020 at Central District Health in the Syringa Room, from 4:00pm to 6:00pm.

Minutes prepared by Courtney Boyce